

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043160

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 55 Primary Registration District No. 5208 Registrar's No. 117 STATE FILE NUMBER

FILED NOV 21 1963

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hale</u> | | c. CITY OR TOWN <u>Hale,</u> | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Farm Home 3 M.S/W</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Rt 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>BROYLES</u> Last <u>BROYLES</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>5th</u> , Year <u>1963</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/10/1895</u> 9. AGE (last birthday) <u>68</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Bosworth, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Will J. Lathem</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Ella Spencer</u> | | 15. NAME OF HUSBAND OR WIFE <u>J.A. Broyles</u> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If no, give war or dates of service) <u>no</u> | | 17. SOCIAL SECURITY NO. <u>no</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u> DUE TO (b) <u>Coronary Thrombosis with myocardial Infarction</u> DUE TO (c) <u>Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension</u> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>11:00</u> a.m. <u>P.M.</u> Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION <u>Hale, Missouri</u> | |
| 21. I attended the deceased from <u>11-5-63</u> to <u>11-5-63</u> and last saw her alive on <u>10-31-63</u> Death occurred at <u>11:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE <u>Norman J. Hansen</u> (Degree or title) <u>D.O.</u> | |
| 22b. ADDRESS <u>HALE Mo.</u> | | 22c. DATE SIGNED <u>11-7-63</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>11/7/1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Hale Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Hale, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Clifford W. Austin</u> ADDRESS <u>F-H Hale, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Nov. 10-63</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Mary Dean</u> | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Clifford W. Austin

Licensed Embalmer No.

3233

P. O. Address

Tena, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.